that alcoholic beverages are commodities included in the retail price index around which so many pay claims revolve; and no present-day chancellor of the Exchequer is likely to risk pushing this up by the public health measure of increasing taxation on alcohol. Political pressure and action is required to have alcohol (and tobacco) removed from the retail price index, so that price control can be used to attempt to control abuse of alcohol.

G A C BINNIE

Berwick-upon-Tweed,
Northumberland

SIR,—In reference to Professor R E Kendall's article (10 February, p 367), can anyone tell me what is the difference between social drinking, drunkenness, alcohol problem, addiction to alcohol, dependence on alcohol, habituation to alcohol and alcoholism? And which, if any, are political problems?

LÉON SHIRLAW

Romford, Essex

SIR,—Returning from overseas, it has concerned me to find that at so many functions now one is offered only alcoholic drinks—the glass of sherry pushed into one's hand or the tray offering only a choice of alcoholic beverages. To opt for a soft drink requires not only mental courage but often considerable perseverance also, with obvious implications especially for the young or the "dried-out" alcoholic.

As a small practical suggestion towards action on alcohol, may I suggest that we in the profession (both as individuals and in running functions) should take a lead by always ensuring that soft drinks are offered alongside the hard.

D A ROCHE

Droitwich, Worcs

SIR,—In the publicity given by your journal (10 February, p 367) and in other news media to the problem of escalating alcoholism and drink-related problems in the UK among the various suggestions for alleviating the problem is the proposal that licensing magistrates have a role to play.

It may not be widely known that powers of licensing committees have been curtailed in recent years in connection with those certificates which allow extensions to the permitted hours. A special hours certificate allows sale of liquor until 3 pm and again until 2 am (3 am in Inner London) where a music and dancing licence is held, where substantial food is served, and where the building is structurally adapted. If the conditions are met the justices must grant the certificate—they have no discretion. The Licensing (Amendment) Act 1976 brought even ordinary bars within the scope of the certificate. This certificate, once granted, does not require renewal at the annual Brewster Sessions, as does an ordinary licence, nor does a transfer to a new licensee need to be made by the local court. A supper hour certificate allowing extended hours in a licensed restaurant must be granted if the conditions are met.

Increasingly one suspects that the main purpose of licensed clubs which obtain a special hours certificate is to provide drinking facilities outside permitted hours. These clubs are proliferating, and in this borough, where there were 2442 convictions for drunkenness in 1978, crime and excessive drinking are frequently related. Violent incidents in a public house, of which there are many, are not considered by the police to be exceptional or to be grounds for objecting to renewal of the licence.

Licensing Committees still exercise control over the issuing of new licences but in many respects their powers have been so eroded by permissive legislation that they are unable to make what should be an effective contribution to the problem of easy accessibility to alcohol.

GWEN D MOLLOY

London NW6

Fatal accidents on non-gritted roads

SIR,—You ask that doctors should notify any deaths resulting from the current industrial troubles in the NHS (10 February, p 364). But it is not only NHS industrial action that may cause death and suffering. I have in this intensive care unit a man with severe multiple injuries following a road traffic accident. His 6-year-old daughter was killed outright at the accident but her 7-year-old friend, who was also a passenger in the car, took several days to die. The cause of the accident was braking while journeying downhill on ice and so skidding into another car. The road had not been gritted as a result of the industrial action. Contact with other intensive care units, when the telephone calls are not censored by the unions, has revealed many similar cases—that is, severely and often fatally injured victims of road traffic accidents resulting from unsafe roads. Despite traffic being reduced to a minimum because of the lorry drivers' strike, the number of damaged vehicles has also never been higher,[1] and with this must be a high number of fatalities.

The Health and Safety Executive is deliberately ignoring this gross disobedience of safety instructions by the work force—it is not even going to investigate it.[2] This is bizarre behaviour for a body devoted to safety. While any one of these accidents could have occurred even with gritting, yet the totality must include a number of deaths, probably a substantial number, directly resulting from the industrial action. The alternative hypothesis is that gritting does not reduce accidents. The silence from the Department of Transport over this matter is noteworthy, verging on a conspiracy—a conspiracy of silence. Could all those involved in the current disputes please pause while the dead are counted?

P J TOMLIN

Intensive Care Unit,
Queen Elizabeth Hospital,
Birmingham

[1] *Observer*, 11 January 1979.
[2] *Birmingham Post*, 2 February 1979.

McMaster revisited

SIR,—Professor G J Fraenkel's analysis of the McMaster programme (14 October, p 1072) is misleading and riddled with errors. His preoccupation with the administration and theory of the school's approach neglects the impact of the student body and individual initiative in creating the McMaster learning experience.

Professor Fraenkel's information is often badly confused—educational prescriptions are not based on phase I investigations. Lectures are not "illegal events," and are openly incorporated into the programme if deemed necessary. His contention that "compared with more conventional schools, real contact with patients and real life medicine is scarce before phase IV" is especially puzzling. Phase I students eagerly seek and find patient contact. The clinical skills course (beginning in phase I) often includes real patients. Parallel electives (beginning in phase II) frequently involve "real life medicine." For example, the popular "community physician elective," taken by 76% of this year's class, allows students to develop interviewing techniques, clinical skills, and problem solving during regular visits to a local general practice.

A successful "experiment in medical education" deserves a more accurate and thorough examination than Professor Fraenkel's cursory sketch.

W D MORTON
Phase II student

McMaster University Medical School,
Hamilton, Ontario

**We sent a copy of this letter to Professor Fraenkel, whose reply is printed below.—ED, *BMJ*.

SIR,—I am grateful for the opportunity to comment on Mr Morton's letter. I do not believe that it is profitable to argue about matters of opinion and the point of view of a Phase II student is necessarily different from that of someone who has spent his life in medical education in a considerable number of English-speaking countries. My views are based on a stay of five months at McMaster with daily discussions with many students and members of the staff. Successive drafts of the manuscript were distributed to and discussed with a large number of members of the staff and all errors of fact which they pointed out have been corrected.

The extent of patient contact is a matter of opinion and it is possible that I have a wider basis of comparison than Mr Morton. It seems to me that his statement "The clinical skills course often includes real patients" by implication proves the very point I am trying to make. Most courses in clinical skills with which I am familiar include real patients all the time.

G J FRAENKEL

School of Medicine,
Flinders University of South Australia,
Bedford Park, South Australia

Automatic blood-gas analysers

SIR,—Having some years' experience with blood-gas analysers, and more recent experience with the Radiometer (Copenhagen) ABL2, I would like to comment on the article by Dr P Rubin and colleagues (20 January, p 156).

The authors quote a four-hour warm-up period, yet the manufacturers quote a two-hour period and I have found less than two hours usually necessary. Aberrant Po_2 results were found by the authors but we have had no such problems when samples are entered correctly. ABL2 users are offered a free course on maintenance and trouble-shooting, and we have found that after this course the calibration checks, flashing lights, and digital voltmeter facility were adequate for diagnosis of simple